

Enhanced Client Engagement Project

Report

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Executive Summary

The intent of the Enhanced Client Engagement project was to test three strategies for increasing the proportion of targeted high-risk Medicaid clients agreeing to participate in care management services: increasing useable information flow, re-engineering client contact processes and material, and use of client "finders". The project interventions focused on initial contact with the Medicaid client and eliciting their agreement to participate, rather than the subsequent step of "engaging" Medicaid clients in beginning a nursing care assessment to develop a care plan.

The project was motivated by low engagement (e.g. beginning a care assessment), blamed on bad addresses and phone numbers, in a previous pilot by the same care management contractor. In the first 9 months (April 2007 – December 2007) of the previous pilot, only 18% of the targeted clients became engaged. Increasing the engagement rate, especially in the start-up period of pilots, is important on two fronts. In a randomized control trial where Medicaid clients are first randomized to a treatment group, then approached to participate in the program, a low engagement rate will make it difficult to show any difference in utilization or cost-savings compared to the control group. In policy-makers eyes, a low engagement rate means that far fewer of the high-cost/high-needs Medicaid clients targeted for care management services will actually take advantage of the opportunity, and could be interpreted to mean clients don't value the service.

Findings:

- Of 406 clients originally targeted in the new pilot beginning in February/ March of 2009, 70% (284) agreed to participate by April 2010, 15 months later. Fifty-six percent (56% or 227) of the targeted clients both agreed to participate and began a care assessment conducted by a nurse.
- Success of the project was aided by the addition of expert consultation and client outreach efforts by a skilled survey research team. The same survey team achieved an 83% contact rate with the surviving target group during a client satisfaction telephone survey in April 2010.
- Subsequent re-design by the contractor and state resulted in much quicker and higher engagement rates (reported as high as 60%) for new clients being enrolled a year after the initial project.

Lessons Learned:

- Up-to-date addresses/phone numbers are the first need; high engagement requires additional steps.
- Incentives and expectations need to be aligned and clarified between partners.
- Outreach staff expertise and organizational culture seems to make a difference in contacting clients.
- Organizing on-going contact/client information for an often transient group requires considerable resources. The design of recruitment/outreach materials and client incentives is important. Use of a return-mail response form delivers better than expected return, particularly from non-English speakers, though in this case the direct impact on engagement outcomes was not large.
- There are many moving parts to successful client engagement and each step needs to be optimized.

I. Background

“Rethinking Care” is an initiative sponsored by the Center for Health Care Strategies (CHCS), aimed at assisting state Medicaid agencies in implementing chronic care management programs for Medicaid clients. The targeted population is adult aged, blind and disabled (SSI) Medicaid clients who have chronic health conditions, are at high risk of incurring future medical expenses and have co-occurring mental health or substance use issues.

The first Rethinking Care project in Washington State was built on a prior chronic care management pilot in operation begun in April 2007. The previous pilot, which did not require a history of co-occurring mental health or substance use for client selection, was a shorter (6 month rather than 12 month) intervention. The pilot was structured as a randomized control trial, where targeted Medicaid clients were randomized to either a group who would be offered care management or to a group that would be offered the intervention a year later. In the first 9 months of the initial pilot (April 2007 – December 2007), only 18% of the targeted clients became engaged. With such a low rate, it was difficult to ascertain any differences between the treatment and control groups. Similar low contact rates with targeted clients were reported in two other care management projects (15% and 12%).

In December 2008, Washington State Medicaid requested a grant of \$10,400 from Center for Health Care Strategies to increase the proportion of targeted Medicaid clients participating in the chronic care management program. Three strategies the state Medicaid agency could implement were identified in an initial project proposal:

- Increase the amount of client contact information supplied to the care management organization, in a manner that is most useful to them, as well as producing the information in a way that minimizes potential for transcription and other errors.
- Re-engineer the process of contacting clients, beginning with the introduction letter through the “warm” hand-off to the nurse care manager.
- Use of a trained “finder”, a person skilled in finding multiple contact points for each client from multiple sources, in coordination with the care management organization’s outreach staff.

The grant funds from CHCS were supplemented by federal matching funds. In addition to resources from the existing state staff on the project, a \$20,000 contract was let with another Washington state agency, the Survey section of the Research and Data Analysis (RDA) division, for consultation and use of “finders” for those clients who were difficult to contact. The contract ended February 28, 2010. A second effort to contact the same clients targeted for the intervention, this time for a client survey, was completed by the end of May 2010, by the same staff that assisted with the initial outreach effort.

The following summary describes the intervention strategies implemented, results and subsequent changes, contributors to lags between agreement to participate and beginning a care assessment and lessons learned from the project.

II. Description of Interventions

A. Enhanced Data Sharing

The first task was to assure that accurate information on the client was going to the contractor in an efficient manner, so they could contact the client by mail, phone or through previous health care providers.

State staff and the contractor examined the files that were going out each month to determine what data elements on the clients were useful, what was missing and what format would be easiest for them to incorporate into their care management information system. The development and maintenance of the care management information system being used by the contractor was being paid for by the state as part of a separate medical home payment, making it even more important that the data interface be efficient.

The review found many opportunities for improvement:

- Rather than pulling addresses from the Medicaid payment system, more current and complete addresses were drawn from the eligibility system, along with more current and more alternative phone numbers and more complete information on the specific language spoken by the client.
- It is not uncommon for programmers to provide data to contractors in whatever format the data is stored, rather than tailoring the output to the contractor's needs. Much of the information was in a format that needed decoding without corresponding plain English fields, and there was no current data dictionary to aid in translation of the codes, for either the state or the contractor.
- The overall file format being provided to the contractor was difficult for them to use. The data file describing each month's continuing and new clients was enhanced, decoded, and converted to two formats, one that could more readily be uploaded to the contractor's information system (xml format) and one that could be readily used by staff (xls format) immediately. Previously it took the contractor a few weeks to read in and process the data. With the revised files, the client information could be readily understood by outreach workers as soon as it was produced.
- Not all data elements requested by the contractor could be gathered and displayed on the monthly list of enrolled clients.

Storage and use of client claims data to find previous health care providers was an issue to resolve. A large data dump consisting of the last year of Medicaid paid claims for each client had been routinely produced for the contractor, with the intent of incorporating it into their care management information system. The cost and effort for organizing and maintaining such data by the contractor (and paid for by the state) was prohibitive, hadn't been implemented and could not serve as a resource for locating clients. Instead, state staff redirected efforts towards development of a web-based, user-friendly interface for claims data ultimately called the Predictive Risk Intelligence System (PRISM). The PRISM tool was made available to the contractor late in 2009. This allowed the contractor to drop the development of a stand-alone claims-based information system at a significant savings, in addition to offering an easy way to view the names, addresses and phone number of the client's past health care providers and other care managers in different systems. Such information was useful in finding clients as well as developing client care plans.

The lessons learned included:

- Not to assume that files routinely generated for large managed care organizations would be appropriate for smaller contractors like those who provide care management services.

- There are usually opportunities to improve the quality and timeliness of client contact data provided to the contractor.
- Not all client data needs to be separately maintained by the contractor in their own database. More efficient data accessing tools like PRISM can streamline the identification of past Medicaid health care and social service providers, which aids in finding clients as well as informing the development of their care plans.

B. Re-engineering Client Contact

With consultation from the Research and Data Analysis division, material used in contacting the client was reviewed and upgraded.

1. Initial Contact by the State. The first step in contacting clients was a letter from the state, indicating that the client was enrolled and had the option to withdraw, per federal requirements. Enhancements included:

- **Actively pursuing updated addresses.** As described above, the State MMIS system did not carry the latest address, so addresses were pulled from the eligibility system. When the letters (which could not be forwarded) were returned to the state with an address correction, another letter was reissued to the new address, the new address was forwarded to the contractor as well as sent to the eligibility system for updating. Previously there had been no repeat mailings or follow-up on new addresses supplied by the post office with either the care management contractor or the eligibility system. In some cases, letters were sent up to six separate addresses before they were not returned. The initial return rate was about 13%, but was reduced to approximately 3% with re-mailings. This required extra state staff time for follow-up.

- **Introductory letter.** The previous introduction letter was reframed (see Appendix) to:

- Describe the additional services the client was entitled to rather than focusing on their option to opt out of the program. The notion of opting out was an artifact of the federal government considering care management as a managed care arrangement, even though none of their services were paid for or screened by the care management organization. The notion of "opting out" had no meaning for the client.
- The colored letter on letterhead was signed in blue ink by the medical directors of both Medicaid and the contractor. Colors draw attention to the letter, letters signed by doctors have more credence in the eyes of clients, and blue ink is supposed to appear individualized.
- On the outside of the envelope, a neon green sticker proclaiming "New Services for You! Please Reply" was placed at an angle on the left side of the address. This distinguished the letter from a bill or an eligibility enquiry. It also allowed outreach workers to say "Remember that letter with the bright green sticker...?".

Each of these initial letter enhancements were based on survey best practices which evidence had shown make a difference in response rate. Each enhancement was not separately assessed. Survey research literature is a good source for even minor letter enhancements that may improve client responsiveness.

- **Response form with pre-paid, self-addressed return envelope.** Previously, a mail-in response form was not used. For this project, a response format was designed by RDA that was simple, colorful and used visual cues, which asked for confirmation of address, best language, phone numbers and best times to call. A paragraph in English and in 20 different languages fitting on one page explaining how to call for assistance with translation or the TTY/TDD line was included in the mailing. Since supplying a response form with a pre-paid, self-addressed envelope was not standard procedure in initial contact of clients, we assessed the practice for response rate and impact on enrollment. We expected few mailed returns, expecting most follow-up contacts to be by phone.

406 clients were enrolled in two waves: 211 clients effective February 2009, and 195 clients effective March 2009. The 211 clients for February 2009 were randomized into two groups: those receiving the regular letter (111) versus those receiving the enhanced letter with pre-paid, self-addressed envelope and response form (100). All those enrolled in March 2009 (195) were sent the enhanced letter with the pre-paid, self-addressed envelope and response form, for a total of 295 receiving the letter enhancement.

Of the 295 clients receiving the enhanced letter and mail-in response form, 64 (22%) responded in some way, either by phone or by letter. The percent of those responding positively by mail (21% - 62 of 295) was higher than the total percent engaged (18%) in the previous project. We did not expect to see that many clients responding by mail rather than by phone. 13 (20%) of the 64 responders were non-English speakers, a higher proportion than that of the group mailed response forms (12%). The languages represented not the norm (Spanish), but the more rare languages. In addition, 6 of the 64 responders initially identified as English speakers clarified that English was not their primary language as listed in the eligibility system. It appeared that non-English speakers were more apt to use the mailed response form, in part to request interpreters.

While the effort to reach more clients through pursuing updated addresses, repeat mailings, enhanced introductory letters and pre-paid, self-addressed envelope with response forms was deemed successful in terms of decreased returned mail and the relatively high response rate of returned response forms, there was an apparent gap in re-contacting with those clients that returned the response form. The response forms were forwarded to the contractor for follow-up. One identified problem was the hand-off to the contractor's outreach staff – either they were not getting the response forms on a timely basis or were not following up the response forms on a timely basis. In some cases, by the time the response forms were followed up with a phone call, the phone number was out of date. Of the 64 responders, 43 were re-contacted by phone and agreed to participate, 6 chose to opt out, 4 did not complete the agreement phase even though they initially sounded willing and 11 were not (or could not) be re-contacted. This was far below expectations. We expected virtually all who returned a response form could be re-contacted and would begin a care assessment.

The lesson learned is that the hand-off from receiving the completed response form to the call back is crucial, and needs to be fairly immediate. Another lesson was that some clients will only interact through mail, which requires a different approach than a phone-based intervention. We felt the mailed response form contributed to having achieved parity in engagement for non-English speakers.

Findings from the February 2009 mailing where there was random assignment to either the regular letter or the enhanced letter with pre-paid, self-addressed envelope and response form showed no statistically measurable difference in the proportion of those ultimately agreeing to participate. For those receiving the enhanced letter and response form, 59% agreed to participate versus 57% with the old letter and no response form. There was a greater difference for those who took the next step and began an assessment (40% versus 33%, respectively). We hypothesize that gaps in response form follow-up and lags between initial contact and scheduling a nurse assessment contributed to less than expected differences in engagement, but we can't be sure.

2. Initial Contact by the Contractor

The contractor sub-contracted with a group internal to the organization for initial outreach to the client. Previously there had been no standardized recruitment script for the outreach workers. With

consultation from RDA, a standardized introduction/recruitment script was created and training for outreach workers was held on best outreach/engagement practices. The contractor used a community grant to purchase \$10 Safeway gift certificates as an incentive for clients to talk with the nurse for the initial care assessment. We cannot separately identify the contribution of offering a gift certificate versus other system changes like higher initial contact rates, however outreach staff reported the incentive was popular with clients.

In conducting the training, RDA staff observed that some staff were uncomfortable about reaching out to clients and asking them personal questions about their health. These workers' traditional role was to receive calls and refer the client to resources, not to aggressively search for clients. Calls were made only during normal business hours. Initially some nurses expressed discomfort with "chasing" clients, as the traditional medical model was to wait for the client to approach the medical field. According to a qualitative study by Toni Krupski (June 2010), the motivational interviewing training received by the contractors' staff was cited by staff as transformational, changing perspectives on how to reach out to clients and how to work with them.

C. Enhanced Outreach for Hard-to-Reach Clients

The low engagement rate of the previous project (18%) was credited by the contractor as largely due to poor address and telephone information provided by the state. RDA survey staff historically had a track record of between 75-80% survey response rates for the same population. As part of the CHCS-funded contract with RDA, the contractor's outreach staff referred to RDA those names they could not contact in at least three attempts. RDA survey staff were instructed to contact the client, confirm the client's agreement to participate, collect the answers to an SF-8 questionnaire on self-reported health status, and then pass the client's contact information to the contractor's nurse. RDA staff entered client contact information directly into the contractor's care management information system. The nurse would then re-contact the client to schedule an in-person care assessment.

1. Characteristics of the RDA Survey Team. The experienced survey team looking for hard-to-reach clients was cited as having three unique characteristics: skilled staff, a positive organizational culture and additional information tools/sources.

- **Skill set.** The Survey unit manager felt that the success of her unit started with hiring the right people. She drew mainly from retired state financial assistance and quality assurance workers, with years of experience in both the state eligibility systems and working with Medicaid clients. The retirees have a strong work ethic. All are part-time state contract workers and have flexible hours. The right mix of skills is important: some focus on finding contact information on the client or the client's family members (requiring puzzle-solving skills), while others are callers, skilled in building trust and instant rapport. Within callers, there are different interaction styles - "the nurturers" versus "the out-going" - so if one caller wasn't successful in making a connection, they could switch to a co-worker with a more compatible style. Staff like and are truly concerned about the clients and their welfare. Most had worked on a national survey which asked questions about sexual history, so asking questions about health status was considered "easy".

- **Positive organizational culture.** Staff are involved in setting overall and weekly goals for engagement. They have high expectations build on prior successes, usually in the 70-80% range. With flexible staff hours, weekend and evening calls can be easily accommodated. Reaching goals is celebrated with cake, celebrations. Staff are involved in creating the engagement "script", brainstorming the best of their lines. They feel like co-owners of the survey. Team debriefing sessions are held where staff lead the discussion on "how can we do better next time".

- **Information tools.** The most common data sources used by RDA were within the state: the Medicaid eligibility system, vital statistics (to search for parents/siblings), employment history, case worker notes and prison records. MetroNet Experian was an additional source, though many clients did not have much of a credit history. One of the strongest tools is the social network the staff bring after so many years in the field. They know, for example, people who serve the homeless and direct tent cities. A hard copy information sheet is kept on each client: what the caller did, when they talked, the responses, etc, so others could pick up the sheet and follow up appropriately.

2. Outcome of Enhanced Outreach. A total of 281 names of hard-to-contact clients were referred to RDA in batches over time, though the contractor's outreach subsequently found and enrolled 4 of this group. The identified hard-to-contact clients represented 68% of the total targeted population. RDA was able to contact all but 13% (36) of the clients referred to them. Sixty-eight percent (68%) of the hard-to-reach referred clients agreed to participate, while 17 (6%) opted out of the program. The remainder (12%) were either ineligible by the time RDA contacted them or had died.

3. Cost Comparison. The additional cost for the effort to find those identified as "hard-to-contact" was about \$88 per client found. The estimated cost for the care manager's outreach contract was approximately \$258 per client found. The RDA survey office felt they could have been far more efficient had they been given more names without such a large time lag between the client's initial identification and when RDA received the names. They also felt that had they been allowed to schedule an assessment date with the nurse, or directly transfer the client to the nurse (referred to a "warm handoff"), they would have had a much higher engagement rate.

III. Results

A. Final Engagement Results. Of the 406 clients originally identified as the first cohort of clients to be targeted for care management, 284 (70%) agreed to participate, while 227 (56%) took the additional step and began a care assessment (the number of clients who completed a care plan as opposed to those who started a care assessment is not known at this time). The proportion of clients who agreed to participate greatly exceeded expectations. The gap between the number of those who agreed to participate (the focus of the Enhanced Engagement grant) and the number who actually began a care assessment caused great concern to the state.

B. Changes Made. By the end of 2009, it was apparent to the care management contractor that their sub-contract with their internal group to provide outreach services was not effective. The additional support for hard-to-reach clients by RDA was also about to expire the end of February 2010. The contractor hired a social worker in January 2010 to serve part-time as the primary outreach worker. By that time, the initial list of 406 clients had been worked over thoroughly. State staff began issuing 25-40 new names at a time in January 2010, and waited for the contractor to confirm the status of each new name (both agreement to participate and initiation of the nurse assessment) before issuing more. Working a list of 25-40 names was more manageable for the part-time worker, compared with having 250 names to follow-up at one time. In particular, calling clients for follow-up four days after they received their introduction letter was considered best practice by the RDA team. According to RDA, the greater the lag between the initial introduction letter and a follow-up outreach phone call, the less likely the client will understand the call and be receptive. Also, working a list of 25-40 completely, then moving on to a new list is more manageable than trying to track who of the 250 have still not been contacted. Finally, by that time, both outreach and nursing staff had completed motivational interviewing training and practice.

To date, the new contractor system consisting of a combination of timely/more complete addresses and phone numbers, enhanced letters and pre-paid response forms, closer turnaround between introduction letter and the first outreach phone call, use of the trained part-time social worker, the \$10 gift certificate (not mentioned in the introduction letter), motivational interviewing, access to PRISM, higher organizational expectations for achievable engagement and a modest-size call list is generating a reported 60% of clients agreeing to participate and beginning the assessment process.

C. RDA Client Satisfaction Survey. After completion of the outreach assistance through February 2010, RDA was asked to conduct a telephone client satisfaction/participation survey of the same 406 clients. Survey staff began calling on March 16, 2010 and the last survey was conducted May 6, 2010. A \$20 grocery store gift certificate was offered for completion of the survey (funded by a private entity). Introductory letters and response forms with self-addressed, pre-paid envelopes mentioning the availability of the gift certificate were used, with a mail-back response rate of 32% (compared to the previous mail-back response rate of 21% without mention of a gift certificate).

RDA found 28 clients were deceased or in hospice, leaving 378 names to contact. Of the 378 remaining clients, 312 (83%) completed the telephone survey; 16 (4%) refused to participate; and only 12 clients (3%) could not be found. Reasons for inability to complete contact with the remaining 10% of clients included no phone, no answer, in jail or cognitively unable to respond/no care-giver available. Even though this list of 406 clients had previously received a lot of attention, the follow-up client satisfaction survey results suggest that the combination of a strong \$20 incentive and professional survey techniques could reasonably be expected to garner a contact rate of at least 80% (not counting the deceased).

IV. Agreeing to Participate versus Starting a Care Assessment

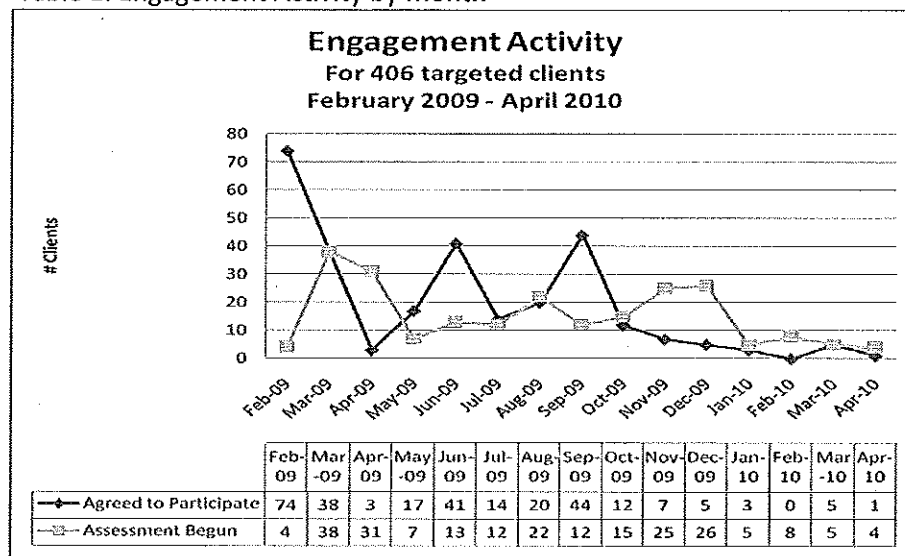
Apart from the specific interventions implemented as a part of the Enhanced Engagement grant to increase the initial contact rate, we found it interesting to look at how the client contact and engagement process changed over time. Of particular concern was the gap between the number of clients who agreed to participate versus the number who actually began an assessment, which was much greater than anticipated.

To understand contributors to this gap, we looked at monthly enrollment patterns; the change in time lag between agreement to participate and beginning the assessment; the impact of attrition from the program due to eligibility, death and other factors on agreeing to participate and beginning an assessment, the impact of transitioning from the previous care management program to the Rethinking Care program, and the stability and inherent incentives of payments to the contractor.

A. Engagement Activity by Month. As illustrated in Table 1: Engagement Activity by Month, the initial focus was on getting clients to agree to participate. Agreement to participate also happened to be the criteria for payment after the client's initial 2 month with the care management contractor. The initial 2 months of guaranteed payment was intended to reimburse for the costs of outreach. By the third month of the Rethinking Care project (April 2009), program management staff asked the contractor to focus on increasing care assessments as opposed to gathering more clients who agreed to participate. It was recognized that the reimbursement structure, by basing payment on agreement to participate rather than beginning an assessment, had the potential to act as a disincentive to focusing on starting care assessment. At the same time, it was noted that clients are most receptive to agreeing to participate shortly after they are first notified of the program. By starting off with such large groups of clients (211

in February 2009 and 195 in March 2009), we inadvertently created a bottleneck of those waiting for a care assessment.

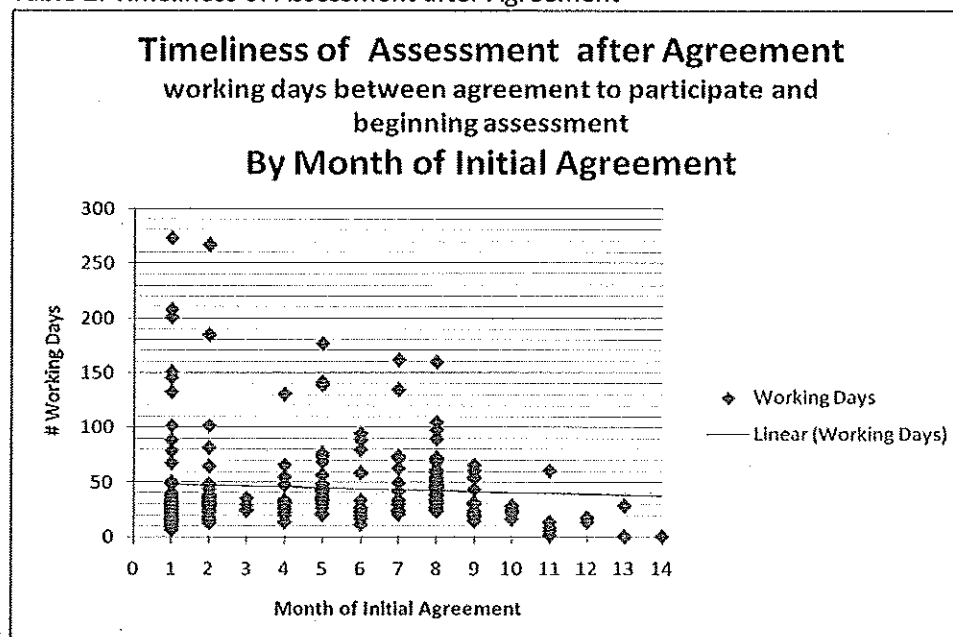
Table 1: Engagement Activity by Month



Source: Monitoring reports, Contractor

B. Time lag. There was considerable lag time between the initial date the client agreed to participate and the date the nurse assessment was begun. The lag time decreased over time (Table 2: Timeliness of Assessment after Agreement). Ideally we would like a system where the gap is much shorter, since payment begins with agreement to participate but service doesn't begin until the assessment begins.

Table 2: Timeliness of Assessment after Agreement



Source: Monitoring reports, Contractor

C. Impact of Attrition. As illustrated in Table 3, by April 2010 of the 406 clients targeted, 323 (80%) were still eligible for the program. Of those still eligible, 201 of 323 (62%) at one point during the last 15

months had agreed to participate and had at least started a nurse assessment. An additional 43 (13%) of those still eligible had at least indicated agreement to participate, though they had not completed the process.

Attrition from the program due to death occurred in 19 of the total cases, most (14) of whom had not agreed to participate. Loss of eligibility occurred for 64 (16%) of the total 406, consisting of 11% of those who had both agreed and started a nurse assessment. So part of the gap (11 of 57) between the number of those who agreed to participate and the number who subsequently started an assessment was due to loss of eligibility, though that did not explain the majority of the gap. Those who died by April 2010 were unlikely to have agreed to participate in the first place, leading us to question whether the most medically fragile clients in the program were suitable candidates to target for care management to begin with. Future research is necessary to see if there is a distinctive profile of those who did not agree to participate or those who are too medically fragile to participate in the program.

Table 3: End Result by April 2010

Status as of April 2010	Didn't Agree to Participate	Agreed to Participate Only	Agreed and Started Assessment	Total
Still Eligible	79	43	201	323
Lost Eligibility	29	11	24	64
Died	14	3	2	19
Total	122	57	227	406

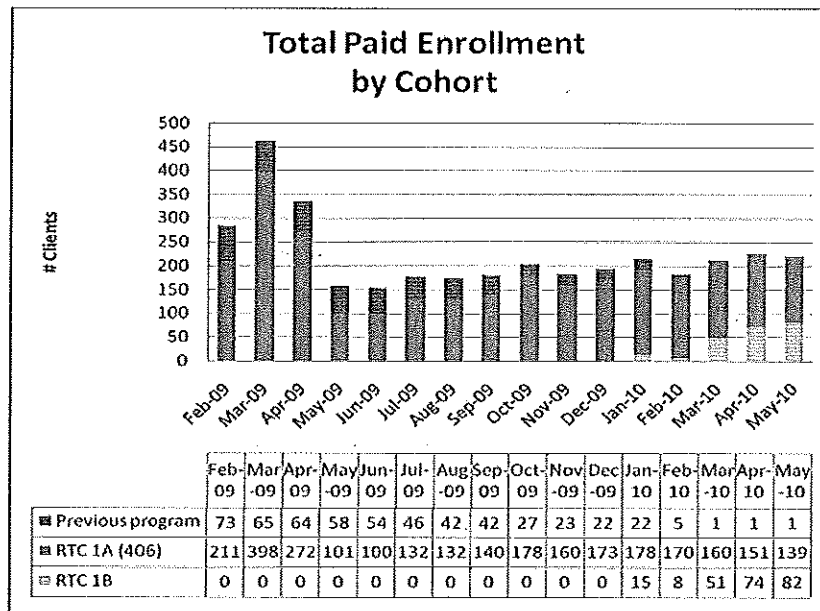
Sources: Monitoring reports, Contractor; RDA Client Outcomes Database for the period Feb 2009-April 2010, as of May 31, 2010

Note: "Lost Eligibility" includes those with retroactive effective dates; "Still Eligible" includes those who opted out of the program; death data in this table may be incomplete given reporting lags.

D. Competing Demands on Nurse Resources. One factor in slower-than-expected engagement was the continuation of care management for clients from the previous care management program. The same nurses who were responsible for beginning the assessment on new clients were actively managing clients from the previous program. Disenrollment of clients from the previous program lasted much longer than expected, stretching out over a year.

Table 4: Total Paid Enrollment by Cohort illustrates the formal paid enrollment by month by program. RTC1A represents the 406 clients who were initially enrolled in February and March 2009 for 2 months each. By May 2009 when the 2-month lock-in expired for many of the 406, clients from the previous program represented 36% of the paid enrollment. Beginning in January 2010 new names were added to the original 406 (RTC 1B) as the contractor added nurse and social worker capacity.

Table 4: Total Paid Enrollment



Source: Enhanced Premium Files, DSHS

E. Payment Structure and Engagement Expectations. As previously described, each cohort of clients randomized to treatment was guaranteed enrollment for the first two months. After the two month interval, they had to agree to participate in order to be enrolled.

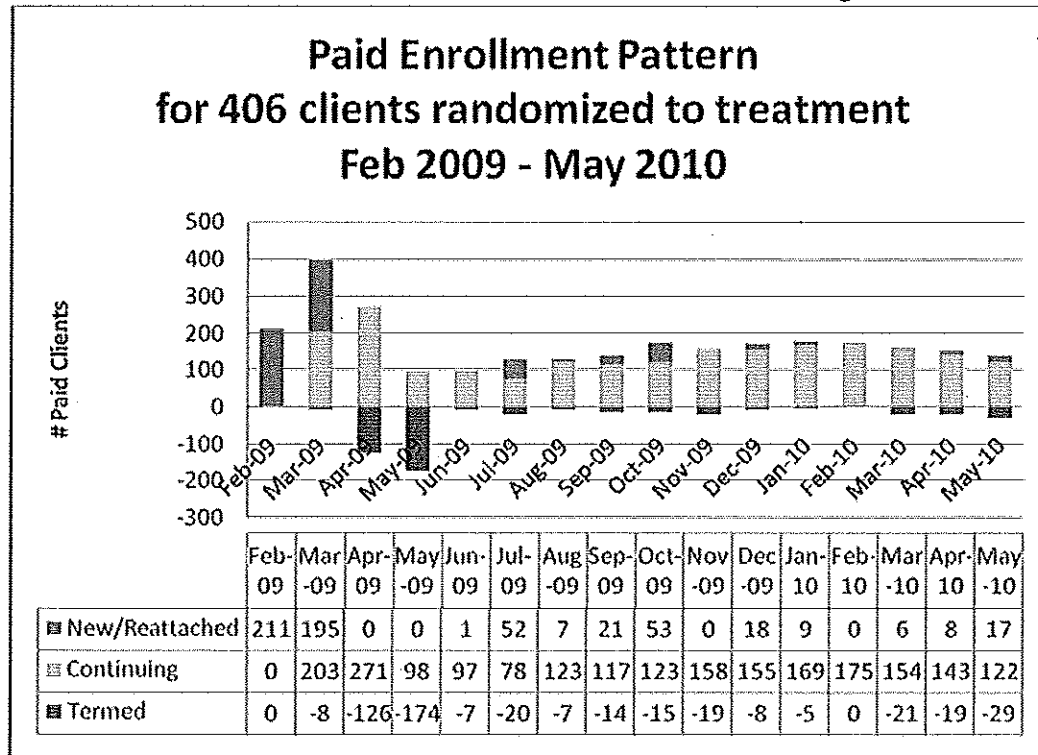
The state enrolled the first cohort of 211 clients in February 2009 for both February and March, and enrolled an additional 195 clients in March 2009 for March and April. By month 4 of the project (see Table 5), the contractor retained only those clients who had agreed to participate in the program. Beginning in June 2009, the fifth month of the project, clients who had originally been assigned in February or March were added back to the enrollment roster (reattached) as they agreed to participate. Terminated clients were those who either had not yet agreed to participate, lost eligibility for the program, died, moved or graduated. Graduation was either determined by the client themselves (feeling they no longer needed the program) or determined by the nurse care managers (the client had achieved sufficient self-care skills or were no longer benefiting from the program).

By having large groups assigned in the first two months of the program, there was considerable variation in enrollment and thus total payment to the contractor month-to-month. The drop in enrollment in April 2009 and May 2009 reignited the contractors' emphasis on getting more clients to agree to participate (see Table 1) and made the gap to date of assessment widen again (see Table 2).

The drop in total payment also led to a request by the contractor for additional clients to be assigned to the treatment group. It was at this point that differences in expectations between the two parties, the state and the contractor, became clearer. The contractor had low expectations of the proportion of clients who could be engaged (based on their historical 18% engagement rate) while the state had much higher expectations of what could be achieved (based on client surveys of 80%). The financial incentives of the payment structure inadvertently encouraged requests for more assigned clients (with a 2 month guaranteed payment) rather than "working the list" of the previously assigned clients. Having the additional resources from the Enhanced Engagement grant for conducting outreach to the hard-to-reach

clients helped bridge the expectation gap, and the ultimate results brought the expectations of both parties more into alignment.

Table 5: Paid Enrollment for 406 clients in the first cohort of Rethinking Care



Source: Enhanced Premium Files, DSHS

F. Other Factors. The observed lag in actually starting a care assessment became the focus of a client survey and was addressed in a qualitative evaluation of the program by Toni Krupski, University of Washington (2010). Trust issues, organization of work flow, barriers to meeting face-to-face and cognitive abilities to participate in their own care were issues cited in her report.

V. Lessons Learned

We found there are multiple opportunities, on the part of the state and our partnering care management organization, to fine-tune our efforts to contact and persuade chronically ill Medicaid patients with co-occurring mental health and substance use issues to participate in a care management program.

Organizing contact/client information requires considerable resources. Providing timely, accurate and useable addresses, phone numbers, spoken language, previous provider information and current eligibility is a necessary first step for effective outreach by the care management organization. Receiving, storing, compiling, and maintaining contact and eligibility information is time-consuming, costly, and often manual for both the state and the care management organization. The IT resources of a care management organization can be expected to be far less than a managed care organization, and requires different IT solutions. This will continue to be an area of growth for us.

Re-engineering the process, tools and staffing for client outreach matters. While results from our initial trial run of response forms with pre-paid envelopes didn't deliver dramatically different engagement outcomes, due in part to processing gaps, they did elicit a respectable response rate of those interested in the program and appeared to help in assuring non-English speakers ways to access the program. Though we couldn't quantify the marginal return of adding a friendly neon sticker to the outside of the envelope, using colored ink on the introduction letter, or lively scripts for callers, we think that adhering to tested survey techniques can only help the ultimate response rate. Mentioning a \$20 supermarket gift certificate in the introduction letter of a client satisfaction survey garnered a 32% mail-back response rate, while not mentioning the incentive but an equally attractive letter led to a 21% mail-back response rate. Medicaid agencies are often limited in their ability to spend federal or state funding in such a manner, so partnering with community groups for client incentives will probably continue to be necessary.

The restructuring of how the contractor approached outreach shows dramatic differences in reaching and assessing clients. There are clear differences in the way client outreach can be organized, in part but not wholly a function of expertise, resources and organizational culture. In a research survey unit, where the value of the survey is in large part determined by maximizing the response rate, the approach to client engagement is detailed, scientific and cause for celebration when response rates are high. Our client outreach efforts greatly benefited from the scientific rigor and strategies from experienced survey staff. The results were also cost-effective compared to the original outreach arrangement.

Getting clients to agree to participate is not the same as getting clients to begin the care assessment. Understanding the dynamics of this difference will continue to be an area of interest to us. Because of the gap, using "agreeing to participate" as the basis for payment appears to be problematic. More thought on how payment is structured is warranted.

Manage the size and comprehensiveness of the recruitment list. Keeping the total list of new clients for each month to a level which can be aggressively processed from initial contact, agreement to participate then to completion of a nurse assessment within a month is ideal. Such a low level of new clients, however, may clash with the cash flow needs of the care management organization. Best practice in a randomized control trial following intent-to-treat protocol would also keep the total clients ever assigned to the project visible to the care management organization every month, with updated contact information and eligibility to encourage such clients not be forgotten, once the initial guaranteed outreach payment is exhausted.

Aligning incentives/expectations between partners. States are drawn to care management programs as a way to address their most costly patients, and ultimately are interested in the population effect of the intervention on that specific target population. They expect a high participation rate for such a generous benefit. The provider community is drawn to care management programs as a way to deliver the best organized care to those patients who are cognitively capable of participating in their care and show promise they can change or be benefited by the help. These may or may not be the same clients that the state sees as most costly. The care management providers are focused on their clinical intervention and want to prove their worth to their professional colleagues by taking referrals. Evaluators of randomized control trials of care management programs want the highest proportion of the randomized to treatment group to be reached, in order to maximize the potential of showing a treatment effect, and see referrals as diluting that effect. These are all different perspectives and must be respected/ acknowledged. Changing expectations on what is achievable takes time and role models.

